5. Notwithstanding the foregoing, if a Provider's Base Year Cost Report indicates that the Provider had Insufficient Experience at a particular level of care, then its Basic PPS Rate for that level of care shall be computed as follows:

a) The G&A and capital cost components shall remain the same for both levels of care;

b) The Provider shall receive the Substitute Direct Nursing Component for the level of care for which it had Insufficient Experience;

c) If the Provider allocated its costs between Levels A and C, then the costs and days allocated to the level of care for which it had Insufficient Experience shall not be considered in calculating its Basic PPS Rates; and

d) If the Provider did not allocate its costs between Levels A and C, then no part of its costs or days shall be allocated to the level of care for which it had Insufficient Experience in calculating its Basic PPS Rates.

e) The calculation of the Basic PPS Rate for an acuity level in which the Provider has Insufficient Experience shall also consider the adjustments that have been incorporated in to the Basic PPS Rate for which sufficient experience exists.

C. Application of Component Rate Ceilings

1. Each Provider's per diem cost components, as calculated in accordance with Section V.B, shall be subject to component rate ceilings in determining a Provider's Basic PPS Rates.

2. For each classification identified in Part IV, component rate ceilings shall be established as follows:

a) For each Provider, multiply the Provider-specific per diem component cost by the Provider's total census days in the base period to determine total cost per

component by Provider. Any per diem component cost that is greater than two standard deviations above or below the statewide mean of the component cost shall be excluded in calculating the component rate ceilings.

b) For each classification identified in Part IV, sum the Providers and totals calculated in Section a above to determine the total cost per component for each classification.

c) Divide the classification component costs calculated in Section b above by the total census days reported in the Base Year Cost Reports for all Providers in the classification to determine an average cost per component by Provider classification; provided, however, that if any per diem costs are excluded because they deviate more than two standard deviations from the statewide mean, then the days associated with those per diem costs shall also be deleted in calculating the average cost per component for the peer group.

d) Multiply the results of Section c above by the following factors to determine the cost component rate ceilings by each Provider classification:

(1) General and Administrative--1.1

(2) Capital--1.1

(3) Direct Nursing--1.15

3. Generally, each per diem cost component of a Provider's Basic PPS Rates shall be the lesser of the Provider's per diem cost component rate calculated under Section V.B or the per diem ceiling for that component , except as noted in Section VIII. D. In the case of the capital component, no Provider shall receive less than $1.50 a day regardless of its cost per day.

4. If a Provider's rate includes a Substitute Direct Nursing Component, then all three of the component ceilings that apply to the Acuity Level for which the rate is being calculated shall be applied.

5. The component ceilings shall not be applied in the following circumstances:

   a) to a Grandfathered PPS Rate;

   b) to a Grandfathered Capital Component (except as provided in Section VI.C.3.a.2);

   c) to Grandfathered Direct Nursing and G&A Components;

   d) to a New Provider or Provider with New Beds whose Basic PPS Rates are, in whole or in part, calculated under the special provisions defined in Part VI. That Part defines the circumstances in which either the component ceilings or some other ceilings will be applied.

6. For the FY 98 Rebasing only, the rate calculation for all Providers shall include the higher of the rates calculated under the following two options:

   a) Sections V and/or VI, increased by the GET and ROE Adjustments and Capital and G&A Incentives, if applicable; or

   b) The Grandfathered PPS Rate.

   c) If the Grandfathered PPS Rate is the lower of the two options, then the Provider shall receive the Basic PPS Rate and all other appropriate adjustments that are defined in this Plan.

   d) If the Grandfathered PPS Rate is the higher of the two options, then the Provider shall also receive the following adjustments or increases to that rate:

(1) For FY 98, one-half of the Inflation Adjustment. For all subsequent PPS years, the Provider shall receive the same Inflation Adjustments that are received by all other Providers.

(2) The GET Adjustment, however, shall only be applied to the incremental increase to the Total PPS Rates that results from the adjustments or increases noted above.

VI. SPECIAL PROVISIONS AFFECTING THE CALCULATION OF BASIC PPS RATES FOR NEW PROVIDERS, PROVIDERS THAT ADD NEW BEDS, AND ACUITY LEVEL D CARE

A. Treatment of New Providers Without Historical Costs

1. The following two types of Providers shall have their Basic PPS Rates calculated, in whole or in part, under this Section VI.A:

a) a Provider that began operating after the Base Year, and therefore has no Base Year Cost Report; or

b) a Provider that begins operating a new facility during the Base Year, and therefore has no Base Year Cost Report that reflects a full 12 months of operations.

2. A Provider that qualifies under one of the above criteria shall submit its projected costs to the Department on forms and in the format defined by the Department.

3. The qualifying Provider shall receive as its Basic PPS Rates the lesser of:

a) its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413 and as modified by this Plan); or

b) 125% of the sum of the statewide weighted averages (including the Inflation Adjustment) for its peer group in each Acuity Level.

4. Commencing on January 1, 1996, the qualifying provider shall receive as its Basic PPS Rates the lesser of:

a) its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413 and as modified by this plan); or

b) the sum of the component rate ceilings for its peer group in each Acuity Level.

c) Section VI.A.3 shall continue to be applied under the following circumstances;

(1) Facilities that, as of December 31, 1995, qualify for and are receiving the New Provider rate.

(2) New LTC projects with certificate of need (CON) approval (if applicable), that either:

(a) have started construction as of December 31, 1995.

(b) have not started construction but have a financial commitment as of December 31, 1995 which contains a penalty clause, in which case the Department may grant a provider's request for an exception based on review of the provider's financial situation.

5. In PPS rate years following the calculation of per diem rates under this Section, the Provider's Basic PPS Rates shall receive the same Inflation Adjustment as other providers.

B. Treatment of New Beds Without Historical Costs

1. A Provider that has expanded beds since or during the Base Year, and therefore has no Base Year Cost Report reflecting a full 12 months of operation with the new beds, shall have

its Basic PPS Rates calculated, in whole or in part, under this Section VI.B.

2. Existing Providers which add new beds during or after the Base Year shall receive Basic PPS Rates that "blend" the rates for the old and new beds.

3. Basic PPS Rates associated with the new beds shall be calculated in accordance with Sections VI.A.3. and VI.A.4. If applicable, the GET Adjustment shall be increased to cover the higher gross excise taxes that will result and the ROE Adjustment shall be increased to reflect any equity invested in the new beds.

4. The result of subsection 3 above shall be multiplied by the number of new beds;

5. The Basic PPS Rates calculated on the historical costs of the existing beds as defined in Section V.A, B and C shall be multiplied by the number of existing beds;

6. The sum of subsections 4 and 5 above shall be divided by the total number of existing and new beds;

7. The rates calculated in subsection 6 above shall be the Provider's Basic PPS Rate for all beds; and

8. The computation shall be performed separately for each acuity level.

C. Transition of New Providers and New Beds into the PPS

1. A New Provider or a Provider with New Beds shall eventually have its Basic PPS Rates calculated in the same manner as other Providers. The transition will begin with the first Rebasing in which the New Provider or Provider with New Beds has a Base Year Cost Report that reflects a full twelve months of operations.

2. Unless the Provider is eligible for the Grandfathered Direct Nursing and G&A Components, the G&A and direct nursing components of the Provider's Basic PPS Rates shall be

calculated in the same manner as existing Providers (including the application of the component ceilings).

3. For New Providers or Providers that added New Beds, the capital component of the Basic PPS Rates shall be determined as follows:

a) The New Provider or Provider with New Beds shall receive the lesser of the following two options as the capital component of its Basic PPS Rates:

(1) its facility-specific capital per diem costs calculated in the same manner as existing Providers (excluding the application of the capital component ceiling); or

(2) its Grandfathered Capital Component (excluding the application of the capital component ceiling); provided, however, that if Provider's facility-specific capital per diem amount after the application of the capital component ceiling is higher than its Grandfathered Capital Component, then the Provider shall receive the higher amount as the capital component of its Basic PPS Rates.

b) In order to implement the preceding section, the Department shall identify the capital component of the Basic PPS Rates for New Providers that existed immediately prior to the implementation of the FY 98 Rebasing. That amount, which is the Grandfathered Capital Component, shall be calculated as follows:

(1) The Department shall compare the New Provider's projected per diem costs (which were used to establish its initial PPS Rates) with its actual capital per diem costs as indicated on the Base Year Cost Report to determine whether the projected capital costs were reasonable. If the Department concludes that the projections were unreasonable, then the Department may adjust the Grandfathered Capital Component accordingly.

(2) If the New Provider's projected aggregate costs in all three PPS rate components exceeded 125% of the sum of the statewide weighted averages, then the Grandfathered Capital Component shall be reduced pro rata. That reduction shall be accomplished by multiplying the projected capital per diem by the Capital Component Reduction Factor.

(3) After applying the Capital Component Reduction Factor, the New Provider's initial projected capital per diem amount shall be increased by the Inflation Factor to remove the effects of varying fiscal year ends and to inflate the per diem to the PPS Year. That amount shall be the capital component of the New Provider's Basic PPS Rates.

c) The Department shall follow the same general procedure in calculating the portion of the capital component for New Beds that was used to calculate the blended capital component for Providers with New Beds.

That process shall include the following steps:

(1) identifying the Grandfathered Capital Component;

(2) if appropriate, applying the Capital Component Reduction Factor;

(3) determining whether the facility-specific or Grandfathered Capital Component rate is appropriate; and

(4) using the appropriate amount to calculate a "blended" capital per diem amount for the Provider.

4. A Provider that added New Beds and meets the defined eligibility tests is entitled to have its direct nursing and general administrative components adjusted as defined below:

a) In order to be eligible for the Grandfathered Direct Nursing and G&A Components, a Provider must meet the following requirements:

(1) The Provider must have both Old and New Beds;

(2) The Provider must have a full twelve months of historical costs for the New Beds reflected in the Base Year Cost Report; and

(3) Immediately prior to the effective date of the FY 98 Rebasing, the Provider must have had in effect a "blended" Basic PPS Rate that included the costs of both the Old and New Beds.

(4) The Provider's Adjusted PPS Rate for FY 98 (excluding the NF and OBRA 87 Adjustments) is less than its Total PPS Rate immediately prior to the Rebasing plus one-half of the FY 98 Inflation Adjustment.

b) A Provider who meets the eligibility tests defined above shall receive the Grandfathered Direct Nursing and G&A Adjustment. As part of the calculation to determine the amount of the adjustment, one-half of the Inflation Adjustment for FY 98 is included. For FY 98 only, no other Inflation Adjustment shall be included in calculating the Provider's Adjusted PPS Rates. Thereafter, the Provider shall receive the full Inflation Adjustment in calculating its Adjusted PPS Rates.

D. Treatment of Providers who provide Acuity Level D Care

1. Providers that furnish Level D services after the Base Year shall submit costs and days to the Department on forms and in the format defined by the Department.

2. Payment for Acuity Level D services will be based on the facility's its reasonable projected allowable costs under Medicare reasonable cost principles of reimbursement (as

defined in 42 C.F.R. chapter 413 and as modified by this Plan). However, if a Provider has historical cost data of providing Acuity Level D services under a state pilot program, the rate will be based on the lesser of the pilot program or the facility's projected costs.

VII. INFLATION AND OTHER MISCELLANEOUS PROVISIONS

A. Application of Inflation and Other Adjustments to Establish Provider-Specific Prospective Payment Rates

1. Annual cost increases shall be recognized by applying the Inflation Adjustment (Section I. Y.) to the historical costs and/or Basic PPS Rates except as noted in (3)(a) of this section.

2. For years in which the Department performs a Rebasing, cost increases attributable to inflation that has occurred since the Base Year shall be recognized as follows:

a) The Basic PPS Rates shall be standardized to remove the effects of varying fiscal year ends;

b) The Basic PPS Rates shall be multiplied by one plus the cumulative Inflation Adjustment;

c) For the purpose of determining the Inflation Adjustment, the Department shall use the most current and accurate data that is then available;

d) To ensure the prospective nature of the system, that data shall not be retroactively modified or adjusted.

3. For years when the Department does not perform a Rebasing, cost increases due to inflation for the upcoming rate year shall be recognized as follows:

a) The Department shall multiply the Adjusted PPS Rate (excluding any rate reconsideration increases) in effect on June 30th of the immediately preceding fiscal year by one plus Inflation Adjustment for the following state fiscal year. Except for the rate period commencing July 1, 1998 through June 30, 1999, the inflation factor would be zero.